

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Kennedy

BUREAU OF VITAL STATISTICS		ARIZONA STATE BOARD OF HEALTH		STANDARD CERTIFICATE OF DEATH	
1. PLACE OF DEATH		County <u>Gila</u> State <u>Arizona</u>		State File No. <u>58</u>	
District or Township <u>Globe</u>		City <u>Globe</u>		Local Registrar's No. <u>121</u>	
2. FULL NAME <u>William Lawson Nail</u>		No. _____		St. _____ Ward _____	
(a) Residence, No. <u>South Globe</u>		(Usual place of abode)		St. _____ Ward _____	
Length of residence in city or town where death occurred <u>14</u> yrs. mos. ds.		How long in U. S. if of foreign birth? yrs. mos. ds.		(If non-resident, give city or town and State)	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>	4. COLOR or RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word) <u>Widowed</u>			
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____					
6. DATE OF BIRTH (month, day and year) <u>September</u>					
7. AGE <u>81</u>	Years	Months	Days	IF LESS than 1 day _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>Store Keeper</u>					
(b) General nature of industry, business or establishment in which employed (or employer) <u>Grocery Store</u>					
(c) Name of employer _____					
9. BIRTHPLACE (city or town) _____ (State or country) <u>Miss.</u>					
10. NAME OF FATHER _____					
11. BIRTHPLACE OF FATHER _____ (State or country) _____ (city or town) _____					
12. MAIDEN NAME OF MOTHER _____					
13. BIRTHPLACE OF MOTHER _____ (State or country) _____ (city or town) _____					
14. Informant <u>Ben Nail</u> (Address) <u>Globe, Ariz.</u>					
15. Filed <u>12/27</u> 19 <u>31</u> <u>L. E. Weyhman</u> Registrar.					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>November 26</u> 19 <u>31</u> Month Day Year					
17. I HEREBY CERTIFY, That I attended deceased from <u>Nov 26</u> , 19 <u>31</u> to <u>Nov 26</u> , 19 <u>31</u> , that I last saw him alive on <u>Nov 26</u> , 19 <u>31</u> , and that death occurred, on the date stated above, at <u>10:55</u> P. The CAUSE OF DEATH* was as follows: <u>uraemia</u>					
(duration) _____ yrs. _____ mos. _____ ds.					
CONTRIBUTORY <u>Prostatitis</u> (Secondary)					
(duration) <u>1</u> yrs. _____ mos. _____ ds.					
18. Where was disease contracted If not at place of death? _____ Did an operation precede death? <u>no</u> Date of _____ Was there an autopsy? <u>no</u> What test confirmed diagnosis? (Signed) <u>A. D. Kennedy</u> , M. D. <u>Nov 28</u> 19 <u>31</u> (Address) <u>Globe, Ariz.</u>					
* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)					
19. PLACE OF BURIAL, CREMATION OR REMOVAL <u>Pinal Cemetery</u>			DATE OF BURIAL <u>11-29-31</u>		
20. UNDERTAKER <u>Miles Moruary</u>			ADDRESS <u>Globe, Ariz.</u>		